



2008

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Recommended Citation

Hoff, Kathleen M., "Family Experience with Eating Disorders Scale: Exploring Reliability and Validity and Evaluating the Clinical Utility of its Use in Treatment" (2008). *Honors Projects*. Paper 14.
http://digitalcommons.iwu.edu/nursing_honproj/14

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Running Head: CLINICAL UTILITY OF FEEDS

Family Experience with Eating Disorders Scale: Exploring Reliability and
Validity and Evaluating the Clinical Utility of Its Use in Treatment

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2008

Abstract

The family plays a significant role in the development and maintenance of eating disorders, and may be equally influential in recovery. The deliberate use of an instrument that addresses the perceived family environment is useful in engaging the family in treatment and enhancing treatment outcomes. The Family Experience with Eating Disorders Scale (FEEDS) was used in this study because it addresses the psychometric deficits common in existing general family assessment instruments and captures family dynamics specific to eating disorders. The 53-item FEEDS was design to illicit the parental perception of the family environment and assesses family dynamics specific to eating disorders, including relational dynamics, interaction skills, and modeling of weight, shape, and eating. A client version of the FEEDS was developed for this study to test the degree of congruence in parent-child perceptions of family dynamics. Moreover, a scoring rubric was created for clinical use based on previous normed data comparing parental responses between families whose child has either an eating disorder, a non-eating disorder psychiatric disorder, or no mental health condition. This paper examines additional psychometric properties of the FEEDS and evaluates its appropriateness for use in clinical practice. Emphasis was placed on the unique challenges of expanding the use of an instrument used only for research purposes to utilize in the clinical setting. A sample of 10 matched dyads revealed adequate levels of reliability; construct validity with known groups was not supported in this sample. Client and parent satisfaction with the FEEDS in the clinical setting was confirmed. The outcome of this study has clinical and research implications; the consistent use of the FEEDS (Parent and Child Versions) will guide the direction of therapy when familial factors are identified at the beginning of treatment and incorporated into the plan of care.

A growing body of literature has been advanced regarding the impact psychological risk factors, including family dynamics, have on the development of eating disorders. Similarly, research emphasis has been placed on variables that affect long-term treatment outcome of eating disorders. The majority of published work represents clinical findings, and the paucity of research publications are plagued with common methodological issues, including the use of diverse family assessment tools with vague or missing reports of psychometric properties and the use of instruments that do not adequately capture family issues specific to eating disorders (Folse, 2007).

Data specific to familial influences on the development and/or maintenance of anorexia nervosa and bulimia nervosa, as well as findings on published outcome studies addressing familial variables in eating disorders, remain inconclusive. Identifying the factors that place individuals at risk for developing an eating disorder is valuable in understanding the etiology, in developing programs for vulnerable groups, in enhancing treatment procedures, and in improving short-and long-term outcomes (Leon, Keel, Klump, & Fulkerson, 1997). Additionally, utilizing family therapy to address factors that may contribute to an eating disorder has been shown to have positive effects on the client, decreasing destructive behavior and rates of family distress (Tantillo, 2006).

A correlation has been established between family functioning and the presence of an eating disorder within the family. Increased risk for disordered eating was identified in those who perceived their family to have low levels of communication, caring, and parental expectations (Neumark-Sztainer, Story, Hannan, Beuhring, & Resnick, 2000). These variables seem to have a major impact on the eating disordered clients. Females diagnosed with bulimia nervosa identified their families to be less cohesive, less emotionally supportive, have high levels of conflict and intimidating environment, and to have family discord concerning communication and interaction than compared to control subjects (Bonne, Lahat, Revital, & Elliot, 2003). Studies consistently find that control subjects report higher levels of family functioning (more cohesiveness, less conflict, secure attachment) than do eating disordered subjects (Bonne et al., 2003; Latzer, Zipora, Eitan, & Laura, 2003; Neumark-Sztainer et al., 2000; Ward, Ramsay, Turnbull, Benedettini, & Treasure, 2000).

Research addressing the degree of concordance between client and parent perceptions of family characteristics was also reviewed. Research examining the congruity between client and parent perception of the familial environment suggests that client views are often inconsistent with parental reports (Jolanda et al., 1997; Madon, Guyll, & Spoth, 2004; Tantillo, 2007). Clients tend to perceive the family in a more negative light than parents. Sawyer, Sarris, Baghurst, Cross, and Kalucy (1988) state, "Adolescents rate their families as significantly less healthy than do their parents. The biggest differences in scores are found between mothers and their adolescent children, and older children rate their families as significantly less healthy than do their parents" (p. 289). It is unknown whether the client's perception of family dysfunction is accurate or due in part to an altered psychological status. Several studies examined females with anorexia nervosa or bulimia nervosa and found that daughters reported a significantly higher degree of dysfunction than their mothers (Dancyger, Fornari, Scionti, Wisotsky, & Sunday, 2005; Gowers & North, 1999; Woodside, Shekter-Wolfson, Garfinkel, & Olmstead, 1995). Regardless of whether these differing views are related to the client's cognitive distortion, it is important to address these

issues in family treatment. This involvement is especially critical because of the relationship between family characteristics and eating disorders; the underlying pathology of these issues needs to be examined during the course of treatment.

Family is an important source of information about eating, eating behaviors, and perceptions of food and body image for children and adolescents (Tester & Gleaves, 2005). Thus, each family member's perception may have a significant impact on the development and maintenance of an eating disorder. Parents who discuss dieting and negative body image enforce the thin ideal and promote unhealthy eating habits. Hirokane et al. (2005) found that mother-daughter discussions about dieting contribute to the likelihood of the daughter dieting. Similarly, Keery, Boutelle, Van de Berg, and Thompson (2003) found that when controlling for body mass index, teasing by a father had a significant impact on the child's internalization of a thin-ideal, body dissatisfaction, and restrictive and bulimic eating behaviors. Further, the idea of a self-fulfilling prophecy in relation to eating disordered clients has been conceptualized (Madon, Guyll, & Spoth, 2005). To illustrate, if a child perceives her mother to have strong opinions about her body and dieting, that child might view all of her mother's comments and behaviors to be related to those beliefs. Madon and colleagues suggest that both parents and children may hold inaccurate perceptions of the other that may affect behaviors.

Many methodologic limitations in both risk factor and outcome studies preclude a complete understanding of factors associated with eating disorder family dynamics (Franko & Striegel-Moore, 2007). The paucity of conclusive findings from risk and outcome studies and the need for consistent use of an instrument with sound psychometric properties to assess family functioning led to the development of the FEEDS. The Family Experience with Eating Disorders Scale (FEEDS) addresses the psychometric deficits in existing general family assessment instruments and captures family dynamics specific to eating disorders. Fifty-three items consistent with a systems perspective of eating disorders were developed to assess parental perception of the family environment.

Results from a content validity study and a pilot study supported further development of the FEEDS (Folse, 2002). Content validity of the FEEDS was established in December 1999; seven professionals and two parents of individuals with eating disorders served as content experts. A total content validity index of .92 for all nine experts combined and .97 for the seven professionals alone was established. Major revisions occurred on two items and minor revisions were made on 18 items. Three items were added to capture sibling relationships. The 53 items were reordered using a random technique. A pilot study was subsequently completed in July 2000. The random sample consisted of 59 parents from separate families of individuals treated in an eating disorders program. Tests of internal consistency demonstrated high reliability of the instrument, while factor analysis supported the construct validity of a reduced 39-item tool. Minor revisions in naming the dimensions were supported by the content validity study and the pilot study, and are reflected in the theoretical diagram of the FEEDS. Results from a 2007 study provide an adequate degree of reliability and validity and support the development of the FEEDS (Folse, 2007). Specifically, the FEEDS was administered to a multi-site sample comprised of three groups: 146 parents of individuals with eating disorders, 35 parents of adolescents with psychiatric disorders, and 100 parents of college students with no known psychiatric illness. Structural equation modeling supported the construct validity of a reduced 30-item instrument

and established subscales of Family Relationships, Interactional Skills, and Modeling of Weight, Shape, and Eating (see Figure 1). A provisional degree of known groups validity was established. Tests of internal consistency and test-retest at two weeks demonstrated adequate reliability. The FEEDS has a continued role in addressing familial variables present in eating disorders and provides a tool for consistent measurement of the unique characteristics.

Purpose

The purpose of this study was to evaluate the degree of reliability in a sample consisting of clients and their parents and to measure the concordance of client and parent responses to the items on the FEEDS. The modified FEEDS (Client Version) was introduced for the first time in this study. Further client and family satisfaction with the FEEDS was assessed to help determine its clinical usefulness in treatment.

Research Objectives

1. To determine to what extent the Family Experience with Eating Disorders Scale is reliable when administered to eating disorder clients and parents
2. To determine the degree of concordance of parent and child responses to the Family Experience with Eating Disorders Scale
3. To determine the degree of satisfaction and clinical utility of using the Family Experience with Eating Disorders Scale

Methods

Subjects

A convenience sample from the OSF Saint Francis Medical Center Eating Disorders Program was used: consecutive clients under the age of 25 and families who presented for treatment were pursued until a sample of 10 self - appointed parental representatives, either male or female, from separate families, as well as 10 matched clients agreed to participate. Thus, the parental participant could be a biologic, step-parent, or adoptive parent. Potential participants were approached by the evaluating and/or treating psychotherapist (who may or may not be the faculty advisor) to confirm eligibility requirements and ascertain willingness to participate before the FEEDS and follow-up opinion surveys were administered. To ensure client safety and appropriateness for participation, the following inclusion criteria were used.

Inclusion Criteria

- Parents whose child, when diagnosed with an eating disorder, listed the parent's home as the primary residence at the time treatment was initiated
- Parents whose child are currently receiving treatment in the Eating Disorders Program
- Parents who can read, write, and understand English
- Clients when diagnosed with an eating disorder, listed the parent's home as the primary residence at the time treatment was initiated
- Clients currently receiving treatment in the Eating Disorders Program

- Clients who can read, write, and understand English
- Clinicians currently providing treatment as a psychotherapist in the Eating Disorders Program
- Clinicians who can read, write, and understand English

The sample at the time of data analysis consisted of ten parent-child dyads. All participants completed a demographic data form attached to the FEEDS (see Appendices A & B). These forms were used to obtain demographic information and these data are summarized in Tables 1 & 2. The clients sampled ranged in age from 12-23 with a mean age of 16.9. Parent participants ranged in age from 37-56 with a mean age of 47.5. The majority (90%) of the sample were Caucasian. Additionally, the majority of parents (90%) had some degree of college education. The sample consisted of mainly intact or blended families with an average of three children in the household. The diagnoses make-up of the clients was: 40% Anorexia Nervosa, 30% Bulimia Nervosa, and 30% Eating Disorder Not Otherwise Specified. Twenty percent of families reported being involved in individual family therapy, 20% were involved in family support groups, and 30% reported being involved in multiple types of family therapy. The remaining 20% of the sample were not involved in any family therapy.

Measures

Perceived familial characteristics were measured by the administration of the FEEDS (Folse, 2007) to both the client and a designated parent. The 53-item tool (see Appendices C & D) took approximately 20 minutes to complete, and involved questions related to Family Relationships, Interactional Skills, and Modeling of Weight, Shape, and Eating. Participants were reminded that they need not answer any question they did not understand or felt uncomfortable answering. Participants were also given the option of not answering questions that did not apply to their family situation. Though clients and parents were instructed to complete all 53 items on the FEEDS, only the parsimonious 30 items supported in previous psychometric analysis were analyzed.

Before the study began, the FEEDS was also revised to allow clients to complete the instrument (see Appendix D), reflecting on a designated parent and their own perceptions of family dynamics. On the face sheet of the instrument, the client was instructed to specify to which parent he/she was referring to ensure matched parent/child responses. Questions on the Client Version were adjusted to permit children to answer questions about their parent. This modification allowed comparison of parent/child responses to the questions and the determination of differences in perception between parent and child.

Parents and clients were also given a survey to evaluate satisfaction with the FEEDS. This survey included 7 questions answered on a Likert scale (1 – extremely dissatisfied, 5 – extremely satisfied). These surveys took approximately 5 minutes to complete. In future research, this survey will be given to clients and family members following a period of treatment after the FEEDS results have been discussed and utilized in treatment. The satisfaction surveys returned to the researchers had been disseminated with the initial FEEDS, which did not allow families to reflect on the pertinence of the FEEDS questions in treatment. Therefore, for this study,

emphasis was placed on the first four questions due to the improper timing of administration of the satisfaction surveys.

Procedure

Institutional Review Board (IRB) approval was granted by the Principal Investigator's affiliate university, as well as the community and hospital IRBs where the research was conducted. Written consent was obtained from all adult clients and parents participating in the study (see Appendices E & F). Written assent and parental consent were obtained for subjects under 18 (see Appendices G & H). No incentives for participation were offered, and subjects were notified that there were no consequences for refusing to participate. Clients and parents were informed the researchers would share the results of the FEEDS with the client's family and the clinician to facilitate treatment, but that like all other aspects of the client's treatment at the Eating Disorders Program, confidentiality would be assured.

Data were collected in the OSF Saint Francis Eating Disorders Program between February and April, 2008. Prior to the initiation of the study, clinicians at the Eating Disorders Program were trained at an in-service led by the Principal Investigator and Faculty Advisor. They were given a copy of the FEEDS (both Parent and Child Versions), consent forms, demographic forms, and satisfaction surveys. Clinicians were instructed to disseminate the FEEDS with the standard battery assessment questionnaires each client receives upon admission.

Clients were informed that the study was voluntary and would not delay their treatment time. Clients were also informed that participation in the study would not replace the standard of care. All participants completed the Family Experience with Eating Disorders Scale (see Appendices C & D) and the demographic data form (see Appendices A & B). A survey evaluating the client and parent satisfaction (see Appendix I) with the tool was also administered. The completed instruments, forms, and surveys were then placed in a mailbox at the Eating Disorders Program and picked up by the faculty advisor. The FEEDS were scored by the researchers according to a grading rubric established by the Principal Investigator (see Figure 2 and Figure 3). A subscale score for each section of questions (Family Relationships, Interactional Skills, Modeling of Weight, Shape, and Eating) was also calculated and returned to clinicians.

Informed consent included the phone number of the Faculty Advisor, whom they could contact during the duration of the study with any questions or concerns. Participants were informed that their participation was completely voluntary and that they could withdraw at any time. Any concerns raised by responses to the FEEDS could also be addressed as part of the treatment.

Statistical Analysis

SPSS 15.0 was used for all statistical analysis. Reliability of the FEEDS was measured through internal consistency and was reported as Cronbach's alphas. Independent t-tests and Pearson's r were obtained to compare parent and child responses to the FEEDS.

Cronbach's alphas were calculated to explore the internal consistency of the FEEDS and its subscales. Because the instrument is in its early stage of development, internal consistency was

established if coefficient alphas of .70 or above were obtained (Mishel, 1998; Nunnally & Bernstein, 1994). Higher values suggest higher levels of internal consistency. Pearson's product-moment correlation was calculated to investigate the degree of correlation between responses. Correlation values range from -1.00, indicating a strong negative correlation, to +1.00, indicating a strong positive correlation between variables (Polit & Beck, 2008). Finally, independent t-tests compare mean differences between client and parent responses to FEEDS questions. T-test values are considered significant if the corresponding p value is less than .05, confirming that results were not related to chance (Polit & Beck).

Results

The 10 matched parent-child dyads were analyzed for internal consistency and construct validity with known groups. Further analysis of within groups differences was withheld due to the small sample size.

Reliability (Internal Consistency)

Cronbach's alphas were calculated for each of the three subscales within the FEEDS: Family Relationships, Interactional Skills, and Modeling of Weight, Shape, and Eating, as well as for total scores for all questions. Reliability was calculated for parent responses, child responses, and combined parent/child responses. For parent responses ($n = 10$), adequate reliability was established in each subscale: Family Relationships ($\alpha = .86$), Interactional Skills ($\alpha = .71$), Modeling of Weight, Shape, and Eating ($\alpha = .81$), and total FEEDS score ($\alpha = .90$). For client responses ($n = 10$), adequate reliability was also established in each subscale: Family Relationships ($\alpha = .72$), Interactional Skills ($\alpha = .79$), Modeling of Weight, Shape, and Eating ($\alpha = .86$), and total FEEDS score ($\alpha = .89$). Finally, combined parent/child responses ($n = 20$) showed adequate reliability for each of the three subscales and the total FEEDS score: Family Relationships ($\alpha = .78$), Interactional Skills ($\alpha = .76$), Modeling of Weight, Shape, and Eating ($\alpha = .87$), and total FEEDS score ($\alpha = .89$).

The degree of reliability supported in the 30-item FEEDS as well as the three subscales for all participants and in each subgroup is highlighted in Table 3.

Construct Validity with Known Groups

Pearson's product moment correlations were calculated to interpret the degree of concordance between parent/child responses on individual questions and each of the FEEDS subscales. None of the three subscales yielded statistically significant results, demonstrated by Family Relationships ($r = -.036$, $p = .881$); Interactional Skills ($r = .078$, $p = .745$); and Modeling of Weight, Shape, and Eating ($r = .062$, $p = .795$).

A strong positive correlation ($r = .684$, $p < .001$) was established between the combined parent and child responses on Family Relationships subscale and the Interactional Skills subscale. The correlation ($r = .402$, $p = .07$) between the Family Relationships and Modeling of Weight, Shape and Eating approached significance. Though discussion of these results is beyond the scope of this study, findings were consistent with previous psychometric analysis of the FEEDS.

Independent t-tests were calculated to compare parent/child scores for each question and each subscale and examine the degree of correlation between family members' responses.

Independent t-tests were run using independent variables with two groups (parent and child) and the dependent variable (FEEDS score), which is scale data. No statistical difference was found between parent and child on either individual questions or scores of Family Relationships ($t(18) = .152, p = .88$); Interactional Skills ($t(18) = -.330, p = .74$); or Modeling of Weight, Shape, and Eating ($t(18) = -.263, p = .79$).

Comparing Means

Mean subscale scores for clients and parents were calculated (see Table 4). None of the subscale scores produced statistically significant differences between parent and child. For the Family Relationships subscale, the mean score for parents was 48.9; for clients, mean score was 49.6. For the Interactional Skills subscale, the mean score for parents was 35.2; for clients, mean score was 34. For the Modeling of Weight, Shape, and Eating subscale, the mean score for parents was 39.9; for clients, the mean score was 38.8.

Means were also calculated for responses to the client/family satisfaction surveys. Responses were scored on a 1 (strongly disagree) to 5 (strongly agree) Likert scale. The responses to the first four questions that pertained to the FEEDS were analyzed. Both parents ($n = 6$) and clients ($n = 6$) felt the questions were easy to understand (parent mean score = 4.3; client mean score = 4.3). Similarly, parents (mean = 4.3) and client (mean = 4.3) felt the FEEDS was an appropriate length, as well as felt comfortable answering the questions (parent mean = 4.3; client mean = 4.0). Responses to the question concerning whether or not the questions pertained to treatment issues yielded lower satisfaction (parent mean = 3.83; client mean = 3.5).

Discussion

Psychometric analysis supports the continued development of both the parent and client version of the FEEDS. Internal consistency was established in all subscales with both versions of the FEEDS. While validity results were not statistically significant, the results of these preliminary data must be interpreted with caution due to the small sample. Additionally, this study is the first time the FEEDS has been utilized in the clinical setting. All prior use of the tool has been for research purposes only, and these results represent preliminary support for use in the clinical setting. It should also be noted that further analysis of data, including within groups differences, will be completed when data collection concludes in February, 2009.

An adequate degree of reliability was established in this sample for the parent responses to each of the three subscales. Though reliability was already established in previous studies with the FEEDS, it is encouraging to see strong degrees of internal consistency with such a small sample size. Additionally, the client subscale scores showed consistent reliability between each of the three subscales and total scores. These results are favorable, as the client version of the FEEDS had not been psychometrically analyzed prior to this study.

Construct validity with known groups was not supported by Pearson's correlation coefficients in any subgroups or in the total FEEDS score. No significant correlation was noted between the parent and child subscale scores. While these results suggest that parent perception of the family environment is unrelated to the child perception, results must be interpreted with caution. The degree of parent-child concordance will be reanalyzed upon conclusion of data collection.

Independent t-tests also yielded statistically insignificant results. The results signify that there are no significant differences between the parent and child responses to the FEEDS questions in this sample. Potential implications of these data include the rejection of findings that suggest differences in parent/child perception. However, due to the limited number of participants in this preliminary data analysis, results must be interpreted with caution. Because the t value necessary for statistical significance is strongly influenced by sample size, smaller samples require a larger t to be significant (Polit & Beck, 2008). Further, a discussion of effect size is not advised because the results were statistically insignificant.

Inability to compare within groups differences restricted analysis. Specifically, differences attributable to gender of clients or parents, age (younger versus older adolescents), number of siblings, severity of illness, eating disorder diagnosis, presence of co-morbid conditions, type and frequency of family therapy, and treatment settings could not be examined. All of these variables may have an impact on an individual's perception. Literature suggests differences in perception due to many of these variables. For example, McNamara & Loveman (1990) found that individuals with bulimia nervosa perceived more dysfunctional family environments than those with other eating disorder diagnoses. Another study found a connection between fathers' lack of communication and the presence of an eating disorder (Miller-Day & Marks, 2006). Dancyger, Fornari, Scionti, Wisotsky, and Sunday (2005) found that an eating disordered individual with coexisting depression rated higher levels of family dysfunction than those without depression. With a larger sample size in this study, it would be imperative to examine these variables and their effect on perceived family environment.

Because clinicians failed to properly disseminate satisfaction surveys, 12 surveys were collected to analyze the degree of satisfaction with the FEEDS. Clinicians were instructed to cease dissemination of the satisfaction survey with the initial distribution of the FEEDS at an in-service conducted during the data collection period. The 12 surveys analyzed demonstrated a strong degree of satisfaction with the instrument; families as a whole agreed that the tool was an appropriate length, the questions were easy to understand, and participants were comfortable answering the questions posed. A question relating to whether the questions pertained to treatment issues yielded a wide variety of responses. These results were not discouraging, as results of the FEEDS were not available at the time the satisfaction surveys were distributed.

Limitations

The most significant limitation in this study was the small number of research participants. With only ten matched parent-child dyads, extensive analysis was implausible. When a larger sample is obtained, further analysis, including within groups differences, will be completed.

Additionally, working with clinicians as data collectors proved to be a major limitation of the study. Despite several in-services, written and verbal instructions, and follow-up calls and visits, clinicians failed to administer the FEEDS to all eligible clients and/or ensure the proper return of the surveys. Over the two months of data collection, there were three new secretaries at the OSFSFMC Eating Disorders Program. It is important to note that the secretaries were responsible for distributing packets to clinicians and making sure all FEEDS tools were returned. Additionally, two out of the five clinicians at the Eating Disorders Program were on medical leave for all or most of the data collection period. Not surprisingly, there were many missed opportunities to administer the FEEDS to clients at the program.

All participants were asked about their participation in family treatment on the demographic form. Since family treatment was not defined for the participants, and clients may have participated in family therapy outside of the OSFSFMC Eating Disorders Program, self report of family therapy was limited to descriptive statistics.

Other limitations included the fairly homogenous population sample as well as the limited data collection time period. The sample consisted of individuals from central Illinois, at one specialized eating disorder program, and with minimal diversity. Two months of data collection yielded a small number of participants; with extended time, more participants would be entered into the study and consequently, further analysis could be obtained.

Clinical Implications

This study supports the continued use of the FEEDS in treatment as well as its continued research analysis. The FEEDS is a valuable instrument for use within the clinical setting in eating disorders treatment. The brief instrument can be incorporated into a standard battery of assessment tools used for evaluation purposes. There is little cost associated with the use of the FEEDS, as well as no specialized skills needed to score the results. The FEEDS takes minimal time and requires only paper and pen to complete.

The modification of the FEEDS for clients in this study has significant clinical implications. By allowing both the family members as well as the clinicians to look at how different family members perceive the family environment, varying perceptions can now be addressed. The FEEDS allows each family member to first assess his/her personal perceptions of family relationships, interactional skills, and parental modeling of weight, shape, and eating. Further, the clinician can use the FEEDS responses to begin dialogue about perceptions that need to be reinforced or modified.

It is increasingly apparent that family therapy is an essential part of treatment for eating disordered individuals, particularly for child and adolescent clients. Some literature suggests that family therapy is even more effective than individual psychotherapy or supportive therapy in adolescents (Dare & Eisler, 1997; Tantillo, 2006). The National Institute for Clinical Excellence guidelines stress that the family should be incorporated into eating disorders treatment – especially treatment of eating disordered individuals younger than 18 (NICE, 2004).

Examining parent-child concordance of the family environment can lead to rich discussion about the implications of perception. Madon and colleagues (2005) state, "Relationships and the interpersonal perceptions and expectations they entail are important because they provide a context whereby one can readily interpret and assign meaning to the events that transpire in the course of each new interaction that occurs" (p. 459). Consequently, the perceptions and expectations can potentially shape behaviors during family interaction so that it may actually change interaction itself. Because of this idea that perception has a strong effect on one's actions and behaviors, it is important to address the issue in family treatment.

Individual family responses may show significant positive or negative correlation, and clinicians can analyze each set of family responses to determine how best to use the results to guide treatment. For example, if a client's results for the Modeling of Weight, Shape, and Eating subscale are particularly low (meaning a high perceived level of dysfunction) but the mother or father's subscale score is particularly high, those results promote discussion about the differences in perception between parent and child. Similarly, if there is a strong degree of parent-child concordance in FEEDS responses, but the clinician notes otherwise throughout family therapy sessions, the therapist can address those issues with the family.

Another concern that must be addressed is the possibility of skewed answers to the FEEDS questions due to the fact that the results are shared with other family members as well as the clinician. While eating disorders clients are aware that being in a treatment program requires a certain degree of disclosure, a distinct possibility exists that clients, parents or both may answer the questions differently knowing the results will be shared. This concept is important to consider when analyzing the results of the FEEDS, and requires clinicians to be particularly observant if paper responses to FEEDS questions do not concur with verbal or nonverbal exchanges between the parent and client. Moreover, if a difference is noted between the FEEDS results and interaction between clinician and family members, that disparity is an important issue to address in family therapy.

Consistent with the literature, engaging the family in therapy requires continuous dialogue between client, family, and clinician (Cook-Darzens et al., 2005). The family must be perceived as an important part of therapy for the client. Each family member must be conceptualized as a resource, and not as a focus of pathology. Family members often have a strong sense of guilt when a child develops an eating disorder; additionally, many family members feel alienated from the eating disordered client's treatment. The FEEDS allows both family members and clinicians to begin that discussion and determine ways to guide treatment to best serve the client and the family system as a whole.

Future research may include the administration of the FEEDS to all family members. Allowing all family members to complete the FEEDS would permit a more holistic view of family functioning. Further, it would provide a way to compare eating disordered clients' perception with sibling perception to analyze the proposed idea of altered perception in eating disordered clients. Including all family members and attaining perceptions of each individual would allow for more comprehensive family treatment. Additionally, predictive validity studies will permit researchers to analyze pre and post treatment FEEDS results to examine differences, as the

treatment process is guided by preliminary FEEDS results. Continued analysis of the instrument will ensure the appropriateness of its use in clinical treatment.

A satisfaction survey for clinicians was developed for this study (see Appendix J), but not disseminated. The survey examines the clinician's perception of the ease and appropriateness of the instrument for use in treatment. It also assesses the clinician's opinion of whether they used the FEEDS scores to guide treatment and help design interventions that promote a healthy family system. Evaluating the clinician's level of satisfaction is imperative because if low levels of clinician satisfaction with the FEEDS exist, the instrument will not succeed in the clinical setting. Regardless of the sound psychometrics of the tool, clinicians must be motivated to utilize FEEDS results in treatment for it to be a worthwhile assessment tool. Future research will include the administration of this satisfaction survey to clinicians and its consequent evaluation.

Finally, additional research is suggested regarding the familial variables that contribute to or maintain an eating disorder. The question of whether or not the family environment plays a factor in the development of an eating disorder or if an eating disorder creates a dysfunctional family environment remains unanswered. It is imperative that future research examine these familial variables using psychometrically sound instruments, including the FEEDS, to assure replication and comparison of findings.

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Table 1 Demographic Data of Parents (n=10)

Age of Parent Surveyed		
Mean	47.5	(6.19)
Range	37-56	
Gender of Parent Surveyed		
Male	10%	
Female	90%	
Current Marital Status		
Married, only once	50%	
Remarried	40%	
Divorced	10%	
Highest Level of Education		
High School Graduate	10%	
Some College	20%	
Bachelors Degree	40%	
Masters Degree	20%	
Doctorate	10%	
Ethnic/Racial Background		
Caucasian	90%	
Asian	10%	
Number of total children		
Mean	3.1	(1.20)
Range	2-6	

Table 2 Demographic Data of Clients (n =10)

Age of Client Surveyed		
Mean	16.9 (3.11)	
Range	12-23	
Gender of Client Surveyed		
Male	0%	
Female	100%	
Ethnic/Racial Background		
Caucasian	90%	
Asian	10%	
Diagnosis		
Anorexia Nervosa	40%	
Bulimia Nervosa	30%	
Eating Disorder NOS	30%	
Age of diagnosis		
Mean	15.4 (2.75)	
Range	11-20	
Setting of treatment		
Outpatient	60%	
Partial Hospitalization	10%	
Multiple Settings	30%	
Involvement in Family Therapy		
Individual Family	20%	
Family Awareness	20%	
Multiple Types	40%	
None	20%	

Table 3 Reliability of Family Experience with Eating Disorders Scale

	<u>Cronbach's</u> <u>Alpha</u> <u>Parent</u> <u>n=10</u>	<u>Cronbach's</u> <u>Alpha</u> <u>Child</u> <u>n=10</u>	<u>Cronbach's</u> <u>Alpha</u> <u>Parent&Child</u> <u>n=20</u>
Family Relationships Subscale	.86	.72	.78
Interactional Skills Subscale	.71	.79	.76
Modeling of Weight, Shape, & Eating Subscale	.81	.86	.87
FEEDS Total	.90	.89	.89

Table 4 Comparison of Subscale Mean Scores for Study Participants

<u>Subscale</u>	<u>Parent/Child</u>	<u>n</u>	<u>Mean</u>	<u>Std Dev.</u>	<u>Std Error Mean</u>
Family Relationships	Parent	10	48.9	11.18	3.53
	Child	10	49.6	9.25	2.92
Interactional Skills	Parent	10	35.2	6.54	2.06
	Child	10	34.0	9.43	2.98
Modeling of Weight, Shape & Eating	Parent	10	39.9	8.29	2.62
	Child	10	38.8	10.27	3.24

Figure 1 Family Experience with Eating Disorders Scale (FEEDS) Conceptual Diagram

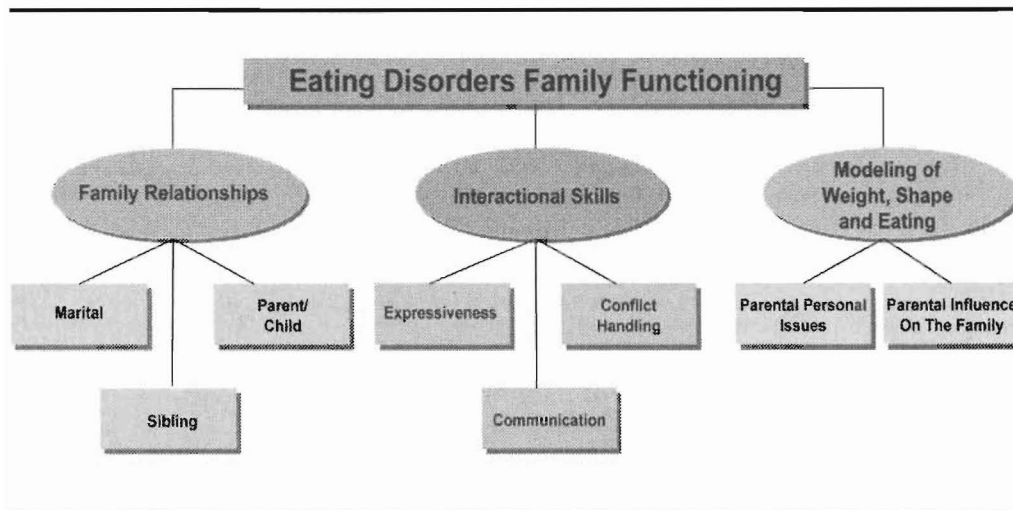
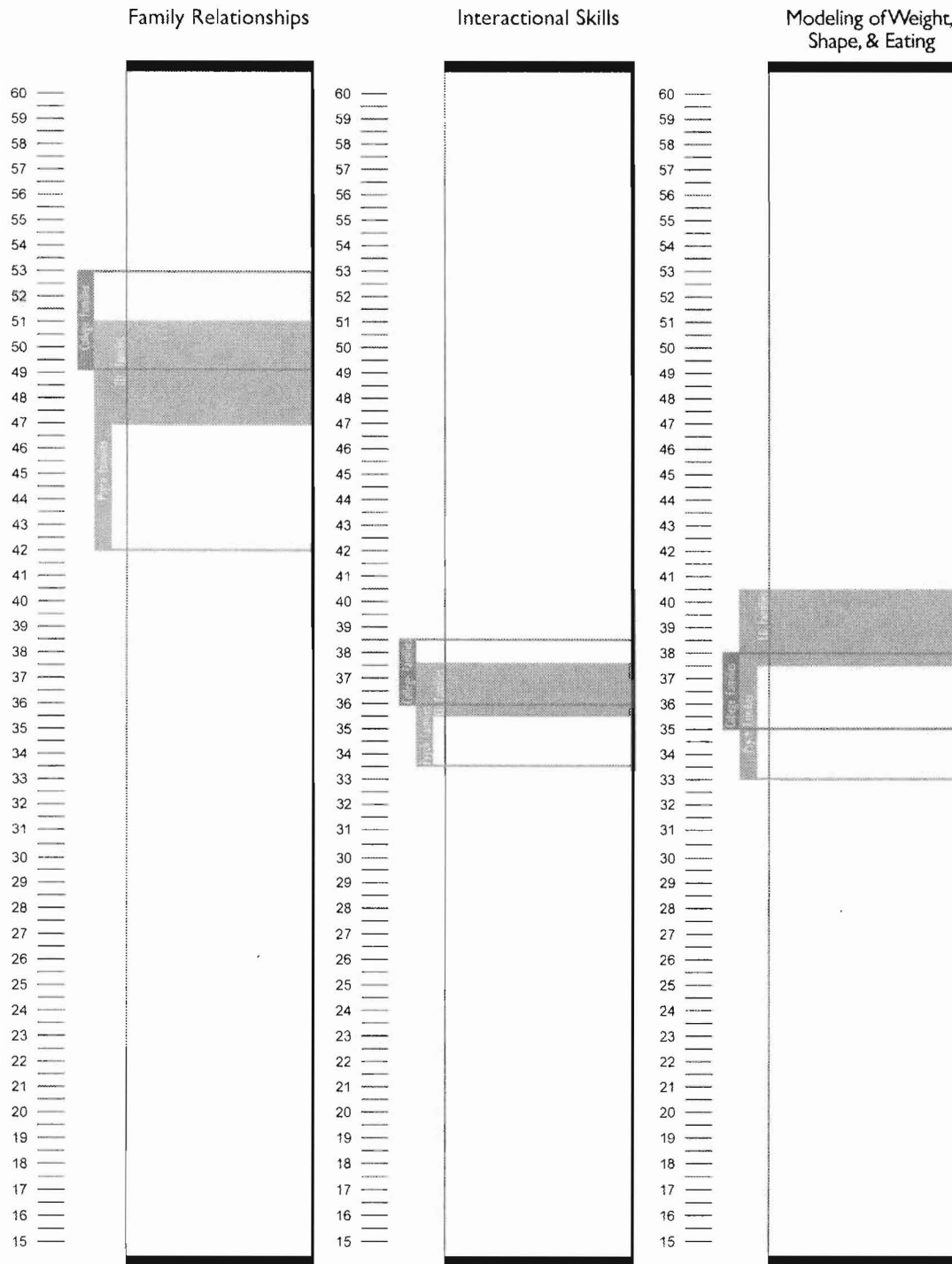


Figure 3 Scoring Rubric – Normative Data Scoring Rubric

Family Experience with Eating Disorders Scale (FEEDS)



Name _____

Date _____

Appendix A: Demographic Data Form (Parent)

Eating Disorders Parent Demographic Data Form

Please indicate the appropriate answer to each question.

1. What is your age? _____

2. What is your gender? M ☐ F ☐

3. Are you the individual your child recognizes as mother/father? Y ☐ N ☐

4. What is your *current* marital status?

Married, Only Once ☐

Never Married ☐

Legally Separated ☐

Remarried ☐

Divorced ☐

Widowed ☐

5. Are you currently married to the individual your child recognizes as mother/father? Y ☐ N ☐

6. What is your highest level of education?

8th Grade Graduate ☐

Some College ☐

Bachelors Degree ☐

Doctoral Degree ☐

High School Graduate ☐

Associates Degree ☐

Masters Degree ☐

If other, please specify _____

7. What is your ethnic/racial background?

Caucasian ☐

African American ☐

Hispanic ☐

Asian ☐

If other, please specify _____

8. How many children have ever considered your home their primary residence? _____

9. What is the eating disorder diagnosis of your child?

Anorexia Nervosa ☐

Bulimia Nervosa ☐

Eating Disorder NOS ☐

10. At what age was your child diagnosed with an eating disorder? _____

11. What is the *current* age of your child who has been diagnosed with an eating disorder? _____

12. What is the gender of your child who has been diagnosed with an eating disorder? M ☐ F ☐

13. In what setting (s) has your child received eating disorder treatment?

Outpatient ☐

Partial Hospitalization ☐

Inpatient ☐

14. Has your family been involved in family therapy? Y ☐ N ☐

If yes, please specify:

Individual Family Therapy ☐

Multi-family Therapy ☐

Family Awareness Groups ☐

Can you provide any additional information that would be helpful in understanding your family structure?

Appendix B: Demographic Data Form (Client)

Eating Disorders Client Demographic Data Form

Please indicate the appropriate answer to each question.

15. Name: _____

16. What is your age? _____

17. What is your gender? M ☐ F ☐

18. What is the last grade you completed in school? _____

19. What is your ethnic/racial background?

Caucasian ☐

African American ☐

Hispanic ☐

Asian ☐

If other, please specify _____

20. What is your eating disorder diagnosis?

Anorexia Nervosa ☐

Bulimia Nervosa ☐

Eating Disorder NOS ☐

21. At what age were you diagnosed with an eating disorder? _____

22. In what setting (s) have you received eating disorder treatment?

Outpatient ☐

Partial Hospitalization ☐

Inpatient ☐

23. Has your family been involved in family therapy? Y ☐ N ☐

If yes, please specify:

Individual Family Therapy ☐

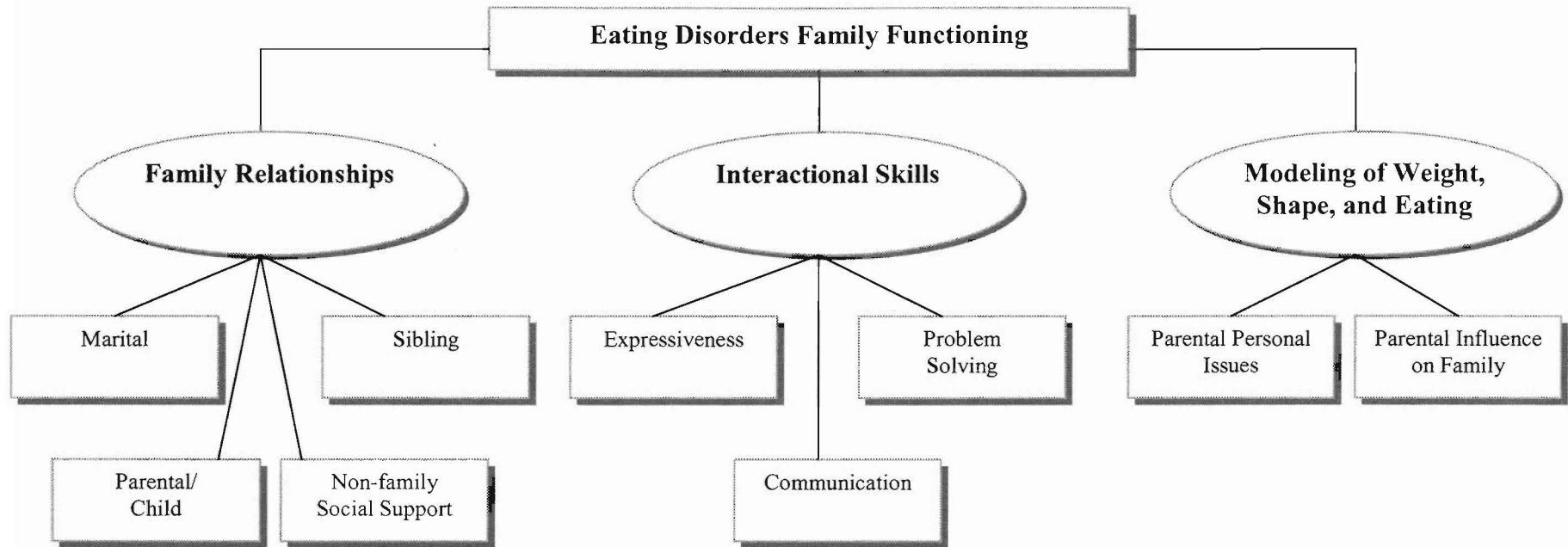
Multi-family Therapy ☐

Family Awareness Groups ☐

Can you provide any additional information that would be helpful in understanding your family structure?

Appendix C: FEEDS (Parent Version)

Family Experience with Eating Disorders Scale (FEEDS) Parent Version



Instructions for Completion of the FEEDS: Please fill in the circle that best represents your degree of agreement with each item. Please complete each item unless it does not apply to your family (i.e. sibling questions if your child is an only child). In the event that your child recognizes both a biological parent and a step parent as a parental figure, please indicate which marital relationship you are addressing on your demographic sheet.

Your Name _____ Child's Name _____
Today's Date _____

Family Experience with Eating Disorders Scale: Parent Version

		Strongly Agree	Moderately Agree	Agree	Disagree	Moderately Disagree	Strongly Disagree
1	I feel effective in dealing with problems as they arise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2	I have been told that I play favorites with my children	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3	I have close friendships with non- family members	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4	It is easier to discuss problems with people outside my family than with my family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5	I have very high expectations of my children	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6	I don't want my children to experience what I did with my weight	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7	I think my children argue with each other more than my friend's children	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8	I have to get input from each child before making a family decision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9	I only share good things about my marriage to my friends	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10	I sometimes hope that a problem will go away if I ignore it long enough	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11	I make comments to my children about their weight	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12	My family usually comes to me with their problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13	I openly express my emotions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14	I am concerned that my children may become fat	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15	I have removed certain foods from the house	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16	I have encouraged my children to diet with me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17	I am afraid of what the future holds for my children	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18	I talk to my spouse before making decisions about the family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19	I believe my children are extremely close to each other	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20	I try to anticipate how people will respond before I say something	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21	I am happy with how my children look	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22	I frequently diet	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23	I make sure my family eats meals together at least a couple of times each week	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24	It is difficult for me to set limits with my children	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
25	I frequently make negative comments to others about my appearance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
26	I consistently enforce family rules with my children	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		Strongly Agree	Moderately Agree	Agree	Disagree	Moderately Disagree	Strongly Disagree

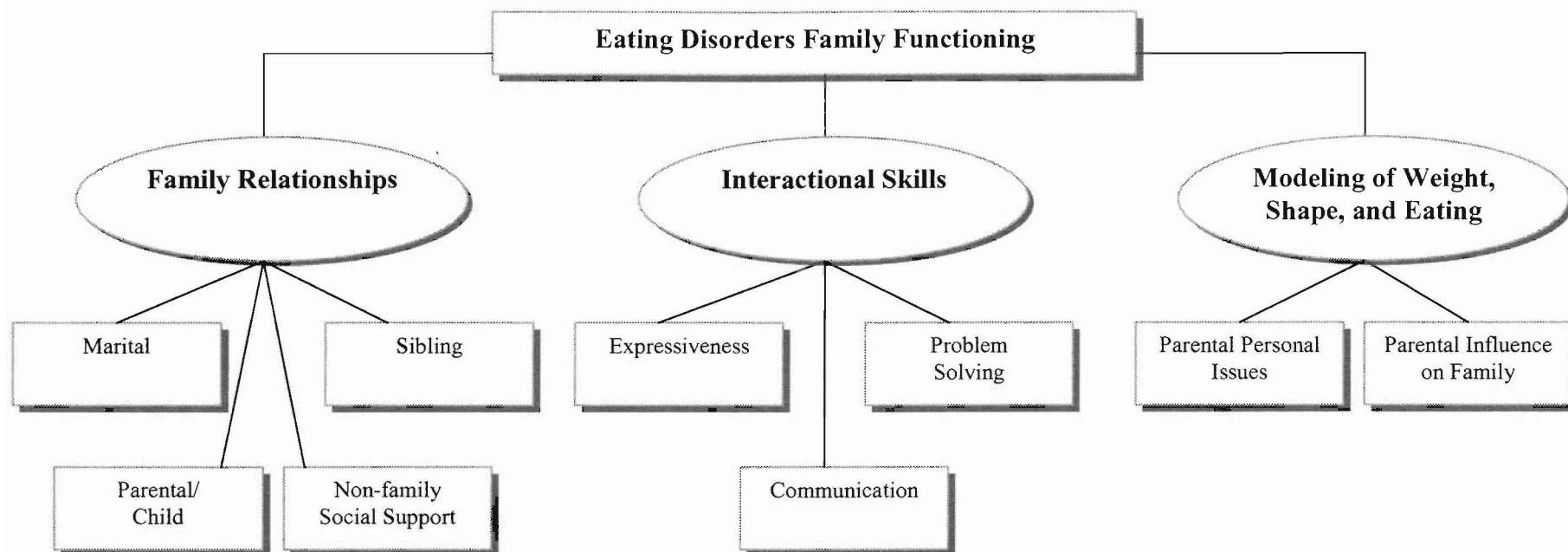
Family Experience with Eating Disorders Scale: Parent Version

[illegible]

Appendix D: FEEDS (Client Version)

Family Experience with Eating Disorders Scale (FEEDS)

Client Version



Instructions for Completion of the FEEDS: Please fill in the circle that best represents your degree of agreement with each item. Please complete each item unless it does not apply to your family (i.e. sibling questions if your child is an only child). In the event that your child recognizes both a biological parent and a step parent as a parental figure, please indicate which marital relationship you are addressing on your demographic sheet.

Your Name _____ Parent Completing Survey _____
 Today's Date _____

Family Experience with Eating Disorders Scale: Client Version

[illegible]

Family Experience with Eating Disorders Scale: Client Version

[illegible]

Appendix E: Written Consent Form for Client 18 or Older

A large, empty rectangular box with a light gray background, intended for the written consent form. It occupies the majority of the page below the title.

Written Informed Consent for Client Age 18 or Older

The purpose of this study is to decide if it would be helpful to add the Family Experience with Eating Disorders Scale (FEEDS) as a routine questionnaire in our program. You may or may not benefit from the results of this research study. However, we hope that this study will help us to improve the care we give to our patients and families. We will be asking 100 families (one client and one parent in each family) to participate. Your participation is voluntary which means you can choose whether or not you want to be involved. This brief assessment is an “add-on” to the current Eating Disorders Program evaluation and will not replace the standard of care. The care you receive will not be affected if you decide not to participate in this study. If you choose to participate, you do not have to answer any questions that make you feel uncomfortable.

Your participation in this research will require that you answer 53 questions about your family at the beginning and at the end of your treatment. Additionally, you may be asked to complete the questions during the course of treatment, but not more often than every fourth session. Answering these questions should take no more than 30 minutes of your time. In addition to your responses, we would like you to answer some general questions about yourself. We will also ask you to complete an opinion survey about what you thought about the FEEDS. If you need help, you can ask your parent/guardian for assistance in completing the FEEDS and opinion survey. Your answers will be shared with your primary therapist so he or she can incorporate your thoughts and feelings about your family into treatment. Your primary therapist may also find it helpful to compare your responses to your parent’s answers and talk about ways to involve your family in your treatment. The results of this study may also be published. However, there will be no information that will be linked to you personally. In other words, no one will know that you participated in this study. Identifying information, including the names of participants, will remain in the Eating Disorders Program. All electronic data will be under password access and coded, with a master list kept as a hardcopy or on a secure network. All hardcopy data will be kept in a locked file cabinet, in a locked office and will be kept for 5 years before being destroyed.

We want you to answer the questions honestly. You will not be paid to participate in this study, and there is no cost to participate. The only alternative choice is not to participate in this study by choosing not to complete the FEEDS questionnaire or the opinion survey. Should you choose not to participate in the study, your treatment will not be affected. This study will end by January 31, 2009. OSF Saint Francis Medical Center has no policy to medically treat or compensate for injuries incurred as a result of participating in biomedical or behavioral research. If you have any questions or concerns about the study itself, your participation in this research study, or if you have questions about your rights as a research subject please contact Dr. Victoria N. Folse at (309) 556-3286. You may also contact Dr. John Haefner at the Peoria Community Institutional Review Board by calling (309) 680-8630 or Dr. Doran French, at the Illinois Wesleyan University Institutional Review Board at (309) 556-3622 if you have additional questions or believe you have experienced injury as a result of your participation.

Signature of Client

Date

Appendix F: Written Consent Form for Parents/Legal Guardians

A large, empty rectangular box with a light gray background, intended for the written consent form. It occupies the majority of the page below the title.

Written Informed Consent for Parents/Legal Guardians

The purpose of this study is to decide if it would be helpful to add the Family Experience with Eating Disorders Scale (FEEDS) as a routine questionnaire in our program. You may or may not benefit from the results of this research study. However, we hope that this study will help us to improve the care we give to our patients and families. We will be asking 100 families (one client and one parent in each family) to participate. Your participation is voluntary which means you can choose whether or not you want to be involved. This brief assessment is an “add-on” to the current Eating Disorders Program evaluation and will not replace the standard of care. The care your child receives will not be affected if you decide not to participate in this study. If you choose to participate, you do not have to answer any questions that make you feel uncomfortable.

Your participation in this research will require that you answer 53 questions about your family at the beginning and end of your child’s treatment. Additionally, you may be asked to complete the questions during the course of treatment, but not more often than every forth session. Answering these questions should take no more than 30 minutes of your time. In addition to your responses, we would like you to answer some general questions about yourself. We will also ask you to complete an opinion survey about what you thought about the FEEDS. Your answers will be shared with your child’s primary therapist so he or she can incorporate your thoughts and feelings about your family into treatment. Your child’s primary therapist may also find it helpful to compare your responses to your child’s answers and talk about ways to involve your family in treatment. The results of this study may also be published. However, there will be no information that will be linked to you personally. In other words, no one will know that you participated in this study. Identifying information, including the names of participants, will remain in the Eating Disorders Program. All electronic data will be under password access and coded, with a master list kept as a hardcopy or on a secure network. All hardcopy data will be kept in a locked file cabinet, in a locked office and will be kept for 5 years before being destroyed.

We want you to answer the questions honestly. You will not be paid to participate in this study, and there is no cost to participate. The only alternative choice is not to participate in this study. Should you choose not to participate in the study, your child’s treatment will not be affected. This study will end by January 31, 2009. OSF Saint Francis Medical Center has no policy to medically treat or compensate for injuries incurred as a result of participating in biomedical or behavioral research. If you have any questions or concerns about the study itself, your participation in this research study, or if you have questions about your rights as a research subject please contact Dr. Victoria N. Folse at (309) 556-3286. You may also contact Dr. John Haefner at the Peoria Community Institutional Review Board by calling (309) 680-8630 or Dr. Doran French, at the Illinois Wesleyan University Institutional Review Board at (309) 556-3622 if you have additional questions or believe you have experienced injury as a result of your participation.

Signature of Parent/Legal Guardian

Date

Appendix G: Written Informed Consent for Parents/Legal Guardians of Minor Clients

Written Informed Consent from Parents/Legal Guardians of Minor Clients

The purpose of this study is to decide if it would be helpful to add the Family Experience with Eating Disorders Scale (FEEDS) as a routine questionnaire in our program. Your child may or may not benefit from the results of this research study. However, we hope that this study will help us to improve the care we give to our patients and families. We will be asking 100 families (one client and one parent in each family) to participate. Your child's participation is voluntary which means you can choose whether or not you want to be involved. This brief assessment is an "add-on" to the current Eating Disorders Program evaluation and will not replace the standard of care. The care your child receives will not be affected if he/she decides not to participate in this study. If your child chooses to participate, you do not have to answer any questions that make you feel uncomfortable.

Your child's participation in this research will require that he/she answer 53 questions about your family at the beginning and end of treatment. Additionally, your child may be asked to complete the questions during the course of treatment, but not more often than every forth session. Answering these questions should take no more than 30 minutes of his/her time. In addition to your child's responses, we would like him/her to answer some general questions about him/herself. We will also ask your child to complete an opinion survey about what he/she thought about the FEEDS. Your child's answers will be shared with your child's primary therapist so he or she can incorporate your thoughts and feelings about your family into treatment. Your child's primary therapist may also find it helpful to compare your responses to your child's answers and talk about ways to involve your family in treatment. The results of this study may also be published. However, there will be no information that will be linked to your child personally. In other words, no one will know that your child participated in this study. Identifying information, including the names of participants, will remain in the Eating Disorders Program. All electronic data will be under password access and coded, with a master list kept as a hardcopy or on a secure network. All hardcopy data will be kept in a locked file cabinet, in a locked office and will be kept for 5 years before being destroyed.

We want your child to answer the questions honestly. Your child will not be paid to participate in this study, and there is no cost to participate. The only alternative choice is not to participate in this study. Should you choose not to consent to your child's participation in the study, your child's treatment will not be affected. This study will end by January 31, 2009. OSF Saint Francis Medical Center has no policy to medically treat or compensate for injuries incurred as a result of participating in biomedical or behavioral research. If you or your child have any questions or concerns about the study itself, participation in this research study, or if you have questions about your child's rights as a research subject please contact Dr. Victoria N. Folse at (309) 556-3286. You may also contact the Peoria Community Institutional Review Board by calling (309) 680-8630 or Doran French, chair of the Illinois Wesleyan University Institutional Review Board at (309) 556-3622 if you have additional questions or believe your child may have experienced injury as a result of your participation.

Signature of Parent/Legal Guardian (if patient
under age 18)

Date

Relationship to Minor

Appendix H: Written Informed Assent for Minor Clients



Written Informed Assent for Minor Client

The purpose of this study is to decide if it would be helpful to add the Family Experience with Eating Disorders Scale (FEEDS) as a routine questionnaire in our program. You may or may not benefit from the results of this research study. However, we hope that this study will help us to improve the care we give to our patients and families. We will be asking 100 families (one client and one parent in each family) to participate. Your participation is voluntary which means you can choose whether or not you want to be involved. This brief assessment is an “add-on” to the current Eating Disorders Program evaluation and will not replace the standard of care. The care you receive will not be affected if you decide not to participate in this study. If you choose to participate, you do not have to answer any questions that make you feel uncomfortable.

Your participation in this research will require that you answer 53 questions about your family at the beginning and at the end of your treatment. Additionally, you may be asked to complete the questions during the course of treatment, but not more often than every fourth session. Answering these questions should take no more than 30 minutes of your time. In addition to your responses, we would like you to answer some general questions about yourself. We will also ask you to complete an opinion survey about what you thought about the FEEDS. If you need help, you can ask your parent/guardian for assistance in completing the FEEDS and opinion survey. Your answers will be shared with your primary therapist so he or she can incorporate your thoughts and feelings about your family into treatment. Your primary therapist may also find it helpful to compare your responses to your parent’s answers and talk about ways to involve your family in your treatment. The results of this study may also be published. However, there will be no information that will be linked to you personally. In other words, no one will know that you participated in this study. Identifying information, including the names of participants, will remain in the Eating Disorders Program. All electronic data will be under password access and coded, with a master list kept as a hardcopy or on a secure network. All hardcopy data will be kept in a locked file cabinet, in a locked office and will be kept for 5 years before being destroyed.

We want you to answer the questions honestly. You will not be paid to participate in this study, and there is no cost to participate. The only alternative choice is not to participate in this study by choosing not to complete the FEEDS questionnaire or the opinion survey. Should you choose not to participate in the study, your treatment will not be affected. This study will end by January 31, 2009. OSF Saint Francis Medical Center has no policy to medically treat or compensate for injuries incurred as a result of participating in biomedical or behavioral research. If you have any questions or concerns about the study itself, your participation in this research study, or if you have questions about your rights as a research subject please contact Dr. Victoria N. Folsie at (309) 556-3286. You may also contact Dr. John Haefner at the Peoria Community Institutional Review Board by calling (309) 680-8630 or Dr. Doran French, at the Illinois Wesleyan University Institutional Review Board at (309) 556-3622 if you have additional questions or believe you have experienced injury as a result of your participation.

Signature of Client

Date

Appendix I: Client/Family Satisfaction Survey

Name: _____

Family Experience with Eating Disorders Scale (FEEDS)
Evaluation for Clients/Families

Please respond to the following questions using the scale provided.	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. The questions were easy to understand	1	2	3	4	5
2. The questionnaire was an appropriate length	1	2	3	4	5
3. The questions pertained to the issues discussed in treatment	1	2	3	4	5
4. I was comfortable answering these questions	1	2	3	4	5
5. My clinician discussed the results and implications of this questionnaire with me	1	2	3	4	5
6. The questionnaire was helpful in allowing me to examine family dynamics	1	2	3	4	5
7. My child/parent and I discussed the results of this questionnaire.	1	2	3	4	5

Narrative Response:

1. Did you have a strong reaction to any of the questions? If so, which one(s)? Please elaborate.

2. Did you think any questions did not directly relate to eating disorders treatment? Please elaborate.

3. How were the results of this questionnaire incorporated into your family's treatment?

4. During this treatment episode at OSFSFMC Eating Disorders Program, indicate the number of family sessions in which you participated:
 - Individual Family Sessions _____
 - Multi-Family (PHP) Sessions _____
 - Family Awareness Group Sessions _____

5. Please describe any additional comments/concerns

Appendix J: Clinician Satisfaction Survey

Family Experience with Eating Disorders Scale (FEEDS) Evaluation for Clinicians

Please respond to the following questions using the scale provided.	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. The questionnaire was easy to administer	1	2	3	4	5
2. Administering the FEEDS to both the client and family was useful	1	2	3	4	5
3. The questions pertained to treatment issues	1	2	3	4	5
4. I utilized the results of this questionnaire to help guide treatment goals	1	2	3	4	5
5. I discussed the results and implications of the FEEDS with my client and his/her family	1	2	3	4	5
6. The FEEDS is a useful tool in designing interventions that promote a healthy family system	1	2	3	4	5
7. I will continue to administer the FEEDS	1	2	3	4	5

Narrative Response:

1. Did you think any questions did not directly pertain to eating disorders treatment? Please elaborate.

2. How did you incorporate the results of this questionnaire in treatment?

3. How did this tool aid in assessing familial risk factors that both contribute and maintain eating disorders? Please elaborate.

4. The FEEDS was designed for parents, but was recently modified to be simultaneously given to clients. How beneficial is administering the FEEDS to both a parent and child? Should it be administered to all members of the family? Please elaborate.

5. Please describe any additional comments or concerns.